U.S. Department of Labor

Office of Administrative Law Judges
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Case No. 1999-BLA-1032

In the Matter of

CHARLES EDWARD COOPER,
Claimant
v.

WESTMORELAND COAL COMPANY,
Employer

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party In Interest

APPEARANCES:

Mary Zanolli Natkin, Esq., For the Claimant
Erika Olsen, Esq., For the Claimant

Mary Rich Maloy, Esq., For the Employer

BEFORE: RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. § 901, *et seq.* (hereinafter referred to as the Act). This case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs, for a formal hearing. Benefits are provided under the Act to a miner who is totally disabled due to pneumoconiosis and to certain survivors of a miner who died due to or while totally (or in certain cases, partially) disabled by pneumoconiosis. Pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

The original claim in this case was filed in 1985, and the relevant procedural history of this case is as follows:

The Prior Claims

1. The Claimant, Charles Edward Cooper, filed a claim for federal black lung benefits on April 1, 1985 (DX-33)[1].

2. The claim was denied by the District Director and on September 27, 1985, Claimant filed a request for a hearing (DX-33 at 220).

3. On March 14, 1989, a formal hearing was conducted by Administrative Law Judge Clement J. Kichuk (DX-33 at 42).

4. On September 12, 1989, a Decision and Order Denying Benefits was issued, finding that, although it had been stipulated that the Claimant had pneumoconiosis arising out of coal mine work, it had not been demonstrated that he was totally disabled due to pneumoconiosis (DX-33 at 39).

5. On September 15, 1989, the Claimant appealed to the Benefits Review Board (BRB) (DX 33 at 33).

6. On March 28, 1991, the BRB affirmed the denial of benefits by Judge Kichuk (DX-33 at 4).

7. On July 18, 1996, the Claimant filed a second (duplicate) claim under 20 C.F.R. § 725.309 (DX- 1).

8. On January 24, 1997, the District Director awarded benefits on the duplicate claim (DX-30).

9. On January 24, 1997, the Employer requested a formal hearing (DX-31).

10. On August 4, 1997, a second formal hearing was held before Administrative Law Judge Stuart A. Levin (DX-47).

11. On May 5, 1998, a Decision and Order was issued denying the claim on the grounds that the Claimant had not demonstrated a material change of conditions since the 1991 denial (DX-47).

12. On May 28, 1998, the Claimant appealed the denial to the Benefits Review Board (DX-50).

13. On July 22, 1998, the appeal was withdrawn by the Claimant (DX-53).

The September 2, 1998 Request for Modification

14. On September 2, 1998, the Claimant submitted additional medical evidence to the

[1] In this decision DX refers to Director's Exhibits; CX refers to Claimant's Exhibits; EX refers to Employer's Exhibits; and TR refers to the hearing transcript.

District Director and requested modification of Judge Levin's decision denying the claim (DX-55).

15. On April 23, 1999, the District Director issued a Proposed Decision and Order Awarding Benefits, finding that Claimant was totally disabled as of January 9, 1999 (DX 80).

16. On May 4, 1999, the Claimant requested a formal hearing on the issues of complicated pneumoconiosis and, therefore, the date on which he became disabled.

17. On May 13, 1999, the Employer requested a formal hearing (DX-83).

18. A formal hearing was held on May 17, 2000, before the undersigned, in Charleston, WV. During the hearing, Director's exhibits 1 through 85[2] were admitted into the record.

19. The Claimant offered 5 exhibits, marked as CX 1-5; CX 1-3 were admitted without objection; Employer objected to CX 4 and 5 on the grounds that they were served on the Employer on April 25, 2000, 22 days prior to the May 17, 2000 hearing (Tr 9-13). Thus, Employer objected unless it was given an opportunity to rebut, pursuant to *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), aff'd on recon., 9 BLR 1-236 (1987) (*en banc*).

20. Claimant responded that the 4th Circuit's opinion in *Bethlehem Mines Corporation v. Henderson*, 939 F.2d 143 (4th Cir. 1991) limits the application of *Shedlock* in cases arising in the 4th Circuit. Claimant argued that the Employer was not surprised by the documents as the physicians whose opinions were submitted had been identified as witnesses to be used in the Claimant's answers to interrogatories. Moreover, Claimant argued that Employer had depositions scheduled and then canceled the depositions of these physicians the week prior to the hearing. Employer responded that Claimant had indeed identified the two physicians in his discovery responses and that indeed the physicians' depositions had been scheduled and canceled. However, Employer argued that "But even if those depositions had gone forward, I would have requested the opportunity to file documentary evidence that was responsive." (TR. 11).

The Court in *Bethlehem Mines, supra*, expressed concerns over the due process aspect of *Shedlock*, stating "That decision appears to hold that whenever a claimant submits evidence just prior to the twenty-day deadline, such evidence constitutes a "surprise" to which the employer must be permitted to respond, even though the evidence was timely and the deadline for submissions has passed....Broadly construed, however, *Shedlock* would eviscerate the twenty-day

[2] DX 86 was excluded, as it is an *ex parte* memo to the file of no relevance in this proceeding. DX 80 was admitted for the limited purpose of documenting any trust funds expended; it is otherwise of no relevance in this *de novo* proceeding (Tr 8).

rule. The Board itself may have recognized this problem by suggesting in its opinion that *Shedlock* did not set forth a specific holding regarding 20 C.F.R. § 725.456(b)(2), but "simply propounded a decision based on the particular facts of that case."

In the instant case, Employer has acknowledged that it was not surprised by the Claimant's use of Dr. Cohen and Dr. Koenig (CX 4 and 5) as Claimant had identified these physicians in his responses to Employer's interrogatories. Under these facts, Employer's argument that it must be given the opportunity to respond post-hearing is rejected. Employer was given ample notice that Claimant intended to use Dr. Cohen and Dr. Koenig, but conducted no further discovery. Thus, Employer cannot and does not argue that it has been unfairly surprised by Claimant's evidence. Under the Court's decision in *Bethlehem Mines, supra*, admission of Claimant's timely evidence does not mandate a post hearing response by Employer.

Therefore, Claimant's exhibits 4 and 5 were admitted, and the record was not held open for a further response by Employer.[3] In addition to his exhibits, the Claimant testified on direct examination (Tr 27-34); there was no cross examination.

21. The Employer offered 23 exhibits, identified as EX 1-23, which were admitted without objection (Tr 22).[4]

22. The record was held open for 30 days for additional evidence to be offered by the Claimant as a result of an order granting Claimant's motion to compel responses to interrogatories, issued on May 20, 2000. Additional evidence was not submitted within 30 days. Instead, Claimant submitted a motion to compel production of documents on June 16, 2000.[5] Employer filed a response on June 30, 2000, objecting on the grounds of privilege. By order issued August 4, 2000, the motion to compel was denied,[6] and the parties were directed to submit written argument within 30 days.

23. Both Claimant and Employer submitted briefs on September 5, 2000. Counsel for

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[3] At the hearing the Employer's objection was taken under advisement, to be ruled upon post hearing. An order admitting CX 4 and 5 without an Employer response (for the same reasons set forth herein) was issued on July 25, 2000.

[4] Objections were raised to repetitive and cumulative evidence. Claimant also requested a post-hearing response to EX 23, if Employer was permitted to respond to CX 4 and 5, post-hearing. However, all objections were ultimately withdrawn (Tr 17-22).

[5] Claimant also proffered, but did not submit, a report by Dr. Wiot dated 7/10/1997 and his *curriculum vitae*.

[6] Grounds for denial of the motion are set out in the August 4, 2000 Order Denying Motion to Compel, which is in the record.

the Director advised by letter dated September 5, 2000, that a brief would not be filed.

24. On September 13, 2000, an order was issued admitting the report of Dr. Wiot as and his *curriculum vitae* CX 6 (the subject of Claimant's proffer submitted with his June 16, 2000 motion to compel). The documents from Dr. Wiot were submitted by facsimile on September 13, 2000. Because this ruling did not occur until after briefs were filed, the parties were granted an additional 10 days for any additional argument. However, no further argument was submitted.

25. Subsequently, the Department of Labor amended the black lung regulations on December 20, 2000, with an effective date of January 19, 2001. These amendments to 20 C.F.R. Part 718 apply to the adjudication of all pending black lung claims. *See* 20 C.F.R. § 718.2. With limited exceptions, the amendments to the Part 725 regulations apply to claims filed after January 19, 2001. *See* 20 C.F.R. § 725.2

The National Mining Association filed a motion for preliminary injunction with the United States District Court for the District of Columbia to enjoin implementation of certain provisions of the amended regulations, *National Mining Ass'n. v. Elaine L. Chao, Secretary of Labor*, Case No. 1:00CV03086. The court subsequently granted intervener status to the United Mine Workers of America.

On February 9, 2001, United States District Court Judge Emmet G. Sullivan issued a *Preliminary Injunction Order* requiring that all pending black lung proceedings before the Office of Administrative Law Judges be stayed "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case."

26. On February 13, 2001 an order was issued directing the parties to submit a brief stating with specificity how application of the amended regulatory provisions at 20 C.F.R. §§ 718.104(d), 718.201(a)(2), 718.201(c), 718.204(a), 718.205(c)(5), or 718.205(d) would affect the outcome of this claim.

27. On February 23, 2001 and February 26, 2001, Counsel for the Claimant and the Director, respectively, filed briefs arguing that the new regulations would have no impact on the outcome of this litigation. On February 23, 2001, Counsel for the Employer filed a brief arguing that the substantive medical criteria in the new Part 718 regulations would affect the outcome of this case. Therefore, the Employer opposed application of the new regulations and requested that if the new regulations were to be applied, that the decision should be stayed, and that the parties must be given a reasonable opportunity to present relevant evidence before the claim is decided. The Employer did agree that if the Director and Claimant agreed that the new regulatory criteria are not to be applied, it did not object to a decision on the merits.

However, 20 C.F.R. § 725.2 provides that the new regulations (with certain exceptions in Part 725) apply to all claims pending on the effective date of the regulations, January 19, 2001. "Claims pending" was defined as claims which were not finally denied more than one year prior to that date. Therefore, the substantive medical criteria in the new Part 718 regulations do apply to this case. As such, the parties cannot agree that they should not apply. As all three parties did not agree that the outcome of the case would not be affected by the new regulations, a decision was stayed pending the outcome of the District Court case.

28. On August 9, 2001, the United States District Court issued its decision finding that the "new" regulations are valid and therefore, dissolved the preliminary injunction. Therefore, the new substantive medical criteria in Part 718 of the regulations are applicable to this case.

29. On August 10, 2001, an order was issued directing the parties to respond as to how they wished to proceed in this case.

30. On August 20, 2001, Counsel for Claimant renewed his argument that the new regulations do not impact this case and requested a decision be issued. On August 20, 2001, Counsel for Employer submitted argument maintaining its position that the regulations cannot be applied retroactively to this case (contrary to the finding of the District Court). Employer further requested that, in the event that the new regulations are applied, the case should be remanded or the record should be reopened to permit an opportunity to submit new evidence addressing changed standards.[7]

31. On August 23, 2001, an order was issued denying the Employer's request for remand and reopening the record in this matter for a period of 30 days for submission of evidence specifically addressing application of the new regulatory standards to this case.

32. Neither party submitted any additional evidence in response to the August 23, 2001, order. On September 27, 2001, the Employer advised by letter that it continues to object to retroactive application of the new regulations and "reserves the right to file additional evidence in the event that the Claimant would file additional medical evidence on remand."[8]

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[7] It is noted that the Employer's response does not actually allege that the new regulatory criteria would affect and be detrimental to the outcome of this case. Instead, the response is couched in terms of "any changes in the new regulatory criteria which would affect."

[8] At the outset, the Employer's reference to "on remand" makes no sense as there is no remand of this case. Employer's statement is treated as a statement that it has no additional evidence to offer in response to the August 23, 2001 order.

33. On October 22, 2001, a letter was submitted by Counsel for the Claimant advising that the Claimant had no additional evidence to offer, and that the parties had mutually agreed that no additional briefs would be filed.

ISSUES

1. Has Claimant established a change in conditions or a mistake in a determination of fact (pursuant to 20 C.F.R. § 725.310), with respect to the May 5, 1998, denial of his duplicate claim (modification of denial of duplicate claim)?

2. If so, has Claimant established a material change in conditions (pursuant to 20 C.F.R. § 725.309), with respect to the Claimant's April 1, 1985, claim for benefits, which was denied after hearing on September 12, 1989, and affirmed by the BRB on March 28, 1991?

3. If so, is the Claimant entitled to federal black lung benefits under Part 718 of the regulations, based upon the entire record?

DISCUSSION

The findings of fact and conclusions of law which follow are based upon an analysis of the record, including all documentary evidence provided, statutory provisions, regulations, case law, and arguments of the parties.

As can be seen from the foregoing, a Decision and Order was issued on May 5, 1998, by Judge Stuart Levin, denying the Claimant's July 18, 1996, duplicate claim under 20 C.F.R. § 725.309. Judge Levin, after conducting a second hearing, found that the Claimant had not demonstrated a material change of conditions since his initial claim was denied by Judge Kichuk. Since the appeal of Judge Levin's decision was withdrawn by the Claimant, that decision became final on July 22, 1998 (DX-53). Since the present claim was filed on September 2, 1998, it is within the one year limitation imposed by 20 C.F.R. § 725.310, and is considered a request for modification of the decision by Judge Levin.

Twenty C.F.R. § 725.310(a) provides that a denied claim may be modified at any time before one year after the denial of a claim, on the grounds of a change in conditions or because of a mistake in a determination of fact. Although there are differences between the regulation (20 C.F.R. § 725.310) in existence prior to January 19, 2001 (effective date of the new black lung regulations), and the new § 725.310, the standard to establish grounds for modification are identical. Therefore, it must be first determined whether the Claimant has established a change in conditions since the May 5, 1998 decision, or whether a mistake was made in a determination of fact in the May 5, 1998 decision. The Claimant argues that he has shown both. (Claimant's brief at 6).

In the original decision issued by Judge Kichuk on September 12, 1989, he found that it had been stipulated that the Claimant had contracted pneumoconiosis arising out of his 32 years of coal mine work, but that it had not been demonstrated that he was totally disabled due to

pneumoconiosis (DX-33 at 39). This decision was affirmed by the BRB on March 28, 1991 (DX-33 at 4). These findings by Judge Kichuk were also not disturbed in the proceeding before Judge Levin. In the case at bar, the Employer has not argued that the Claimant did not work for 32 years in the coal mines, and has not argued that the Claimant does not have simple coal workers' pneumoconiosis. No evidence has been offered to suggest contrary findings or a mistake in a determination of these facts or a change in conditions. I have reviewed the record and find that no grounds exist to disturb these findings. Therefore, I find that it has been established that the Claimant worked for 32 years in the coal mines and that he has contracted simple pneumoconiosis caused by his coal mine dust exposure.

Therefore, it remains to be determined whether the Claimant has established grounds for modification with respect to the issue of whether he is totally disabled due to pneumoconiosis. Because this record is quite large, and because the old evidence and the newly submitted evidence must be compared, the following is a summary of all medical evidence in the record:

X-RAY EVIDENCE:

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
04 03 1984	DX 33-215	Richard Thompson	q/t; 6 zones; 1/1
04 08 1984	DX 33-214	James M. Wills	no acute process; mild chronic interstitial and nodular change, probably due to 35 years in the mines.
04 11 1984	DX 33-213	Richard Thompson	q/t; 6 zones; 1/1
06 10 1985	DX 33-252	Maurice Bassali, B	p/q; 6 zones; ½
06 10 1985	DX 33-255	E. N. Sargent, B, BCR	q/s; 6 zones; 1/1; no large opacities
10 01 1985	EX 5	William W. Scott, B, BCR	Film quality 2, minimal underexposure; negative for pneumoconiosis; Fracture ribs; subtle fibrosis with few small nodules in subapical portion upper lobes and few scars in left apex near apical pleural thickening compatible with Tb unknown activity, probably healed. Subtle scars or nodules in lateral periphery RUL are partly hidden by pleural reaction or fibrosis from healed rib fractures. Minimal obesity.
10 01 1985	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
10 01 1985	DX 73	E. N. Sargent, B, BCR	p/s; 6 zones; 1/1; category A large opacities; tb ?left apex; rule out active tbc??. Need apical views, correlate clinically
10 01 1985	EX 7	Young Kim. B, BCR	Film quality 2 underexposure; negative for pneumoconiosis; several focal densities in both upper lungs suggestive of granulomatous process, unknown activity.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
10 01 1985	EX 5	Paul S. Wheeler, B, BCR	Film quality 2, underexposure; negative for pneumoconiosis; subtle small nodular infiltrate in lateral portion RUL and in subapical portion LUL with few linear scar in lateral left apex near focal apical pleural thickening compatible with TB unknown activity, probably healed. Probable minimal obesity and no other abnormality.
10 01 1985	CX 4	Robert A. Cohen, B	Film quality 2, rotated; pneumoconiosis q/p, 6 zones 1/1; Category A large opacities
10 13 1985	CX 1	M. S. Alexander, B, BCR	p/q; 2/2; film quality 1; some r opacities in upper zones; areas of coalescence in right upper zone; no large opacities
09 08 1986	DX 33-198	J.L. Leef	Nodular fibrosis consistent with occupational pneumoconiosis. The heart is not enlarged.
09 02 1992	EX 5	Paul S. Wheeler, B, BCR	Film quality 2, slight underexposure; negative for pneumoconiosis; Few densities lateral right upper lung and left apex compatible with Tb, unknown activity.
09 02 1992	EX 5	William W. Scott, B, BCR	Film quality 2, underexposure; negative for pneumoconiosis; few peripheral radiodensities upper lungs compatible with healed Tb. rib fractures.
09 09 1992	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality; 1 Areas of coalescence are present in the left upper zone and there is now a 25 x 10mm Category A large opacity of complicated pneumoconiosis in the right upper zone in the area where coalescence was seen on the 10 13/85 x-ray; no signs of superimposed acute cardiac or pulmonary disease are present and specifically there is no evidence of tuberculosis; healed fractures;
09 09 1992	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
09 09 1992	EX 7	Young Kim. B, BCR	Film quality 2 underexposure; negative for pneumoconiosis; subtle densities in the periphery of both upper lungs. Likely old healed granulomatous process. Old healed rib fractures, rt. side
09 09 1992	CX 4	Robert A. Cohen, B	Film quality 2, rotated; pneumoconiosis q/p, 6 zones ½; Category A large opacities; rib fractures
09 09 1992	DX 71	E. N. Sargent, B, BCR	q/s; 6 zones; 1/1; no large opacities; fractures; tb?
07 28 1995	DX 42	Gregory J. Fino, B	negative for pneumoconiosis

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
07 28 1995	DX 25	William W. Scott, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Probable focal fibrosis due to healed tb left apex and lateral right upper lung. Healed fracture right clavicle with inferior displacement distal portion. Healed fractured right 5th 8th ribs.
07 28 1995	DX 23A[9]	James R. Castle, B	p/q; 6 zones; No large opacities; fractures; Multiple old rib fx on R. Pleural scar adjacent to rib fx. Old R clavicle fx.
07 28 1995	DX 26	Young Kim, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Multiple old healed rib fractures, rt posterior & lateral old healed fx aspect rt clavicle. Non-specific fibrosis in both apices, prob from old granulomatous process. hyperinflated lung.
07 28 1995	DX 28	Ralph T. Shipley, B, BCR	negative for pneumoconiosis; tuberculosis
07 28 1995	CX 6	Jerome F. Wiot, B, BCR	Acceptable film quality; pneumoconiosis q/p, 6 zones, ½; Category B large opacities in both upper lung fields; fracture of right clavicle ununited; complicated coal worker's pneumoconiosis.
07 28 1995	DX 25	Paul S. Wheeler, B, BCR	negative for pneumoconiosis; underexposed film; fractures; healed fracture with moderate deformity right mid clavicle and few healed right posterior rib fractures. Probable oval fibrosis rather than mass in subapical portion Lul and periphery RUL, 4 MM nodule compatible with granuloma in lateral Rul or pleura between anterior Ribs-2-3 and few tiny scars in both apices compatible with healed TB. No evidence of silicosis or CWP.
07 28 1995	DX 29	Harold B. Spitz, B, BCR	negative for pneumoconiosis; fractures; tuberculosis
02 19 1996	DX 37	Paul S. Wheeler, B, BCR	negative for pneumoconiosis; film quality 3; fractures; tuberculosis; Oval 1.5x4-5 cm mass compatible with fibrosis in lateral periphery RUL and oval 2 cm mass compatible with fibrosis in subapical portion LUL. Both are surrounded by few tiny linear scars some extending to pleura compatible with healed conglomerate TB. Healed fracture right mid clavicle with override and deformity and few healed right rib fractures. Approximate ctr: 13.5/33 excluding epicardial fat. Underexposure PA but lateral but central lung detail is good and lateral with also good quality with no evidence of silicosis or CWP.

[9] The exhibit appeared in the record between DX 23 and DX 24 but was unnumbered. It has now been numbered DX 23A.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
02 19 1996	DX 37	William W. Scott, B, BCR	negative for pneumoconiosis; film quality 3 underexposure scapula overlap; fractures; Multiple healed right rib fractures. Associated thickened pleura or pleural or lung mass. Advise CT to further evaluate. 1.5 cm mass left apex - cannot r/o cancer. Old fracture right mid-clavicle.
02 19 1996	DX 35	James R. Castle, B	q/s; 6 zones; 1/1; film quality 2 (too light); fractures; Old rib fx on R with scar in same area. Old granulomatous dis LUZ.
08 09 1996	DX 13	D. Gaziano, B	p/p; 6 zones; 1/1; "A" large opacities; fractures; tuberculosis; "bilateral apical density rule out T.B. Need see M.D."
08 09 1996	DX 27	Paul S. Wheeler, B, BCR	q/s; 2 zones; 0/1; no large opacities; underexposed film; fractures; tuberculosis; Few small nodules and linear scars in periphery upper lobes compatible with TB unknown activity, probably healed. Probable few tiny calcified granulomata in periphery RUL. Healed right rib fractures and right mid clavicle. Oval 1x2 CM mass or scar or pleural fibrosis in lateral portion right upper chest between anterior ribs-2-3 / compare to old films or get CT scan. Peripheral upper lobe disease favors TB over pneumoconiosis.
08 09 1996	DX 12	Paul Franck, B, BCR	p/p; 6 zones; 1/1; no large opacities; Deformity of R clavicle & R upper ribs with associated thickening of pleura - old injury.
08 09 1996	DX 24	James R. Castle, B	p/q; 6 zones; No large opacities; fractures; Multiple old rib fx on R. Pleural scar adjacent to rib fx. Old R clavicle fx.
08 09 1996	DX 14	M. I. Ranavaya, B	p/q; 6 zones; 2/3; "A" large opacities; Vague densities are identified in both apices, also noted is a large opacity of about 1 cm. in size, projected in the Rt. second inter space which likely relates to the overal fibrotic change with pneumoconiosis. The Rt upper lobe is more affected than the Lt. Moderate bilateral apical pleural thickening is also seen. But without prior studies for comparison, close follow-up exam & CT scan would be necessary to exclude progressive pathology particularly in the Rt upper lobe.
08 09 1996	DX 42	Gregory J. Fino, B	negative for pneumoconiosis

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
08 09 1996	DX 27	William W. Scott, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Healed fractures right 5th - 8th ribs and right clavicle. Density lateral right apex may be pleural thickening associated with fractures but cannot r/o mass. Advise CT or F/U in less than 6 mo. Minimal scarring left apex compatible with healed Tb.
08 09 1996	DX 29	Young Kim, B, BCR	q/s; 2 zones; 0/1; no large opacities; underexposed film; fractures; tuberculosis; focal il-defined densities in both apices, suggesting fibrosis or granulomatous process with unknown activity. underexposure - suggest follow-up of lng parenchymal old healed rib fxs (rt) & clavicle changes.
08 09 1996	CX 6	Jerome F. Wiot, B, BCR	Acceptable film quality; pneumoconiosis q/p, 6 zones, ½; Category B large opacities in both upper lung fields; fracture of right clavicle ununited; complicated coal worker's pneumoconiosis.
08 27 1996	DX 29	Harold B. Spitz, B, BCR	negative for pneumoconiosis; fractures; tuberculosis
08 27 1996	DX 25	Paul S. Wheeler, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Healed fracture with moderate deformity right mid clavicle and few healed right posterior rib fractures. Probable oval fibrosis rather than mass in subapical portion LUL and periphery RUL, 4 MM nodule compatible with granuloma in lateral Rul or pleura between anterior Ribs-2-3 and few tiny scars in both apices compatible with healed TB. No evidence of silicosis or CWP.
08 27 1996	DX 25	William W. Scott, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Probable focal fibrosis due to healed infection such as tb, left apex and lateral right upper lung. Healed fractured right clavicle and right ribs 5-8.
08 27 1996	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
08 27 1996	EX 8	Kirk Hippensteel, B	Film quality 1; pneumoconiosis p/q; six zones; 1/1; rib fractures with pleural bruising or inflamation
08 27 1996	DX 28	Ralph T. Shipley, B, BCR	negative for pneumoconiosis; tuberculosis; bi-apical nodular opacities stable since 7/95, most likely not large opacities of CWP. Probably healed TB or Histo.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
08 27 1996	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality 1; No significant change in the profusion of small opacities; Areas of coalescence are present in both upper lung zones and a large opacity measuring approximately 20 x 20mm has now developed in the left upper zone. The chest x-ray is otherwise unchanged. No intervening pneumonia, pleural effusions or adenopathy are present, and specifically there is no evidence of tuberculosis.
08 27 1996	CX 6	Jerome F. Wiot, B, BCR	Acceptable film quality; pneumoconiosis q/p, 6 zones, ½; Category B large opacities in both upper lung fields; fracture of right clavicle ununited; complicated coal worker's pneumoconiosis.
08 27 1996	CX 4	Robert A. Cohen, B	Film quality 1; pneumoconiosis q/p, 6 zones ½; Category A large opacities; rib fractures; large opacity Rt upper lobe.
08 27 1996	EX 10	A. Dahhan, B	Film quality 1; negative for pneumoconiosis; rib fractures
08 27 1996	DX 42	Gregory J. Fino, B	negative for pneumoconiosis
08 27 1996	EX 9	Bruce N. Stewart, B	Film quality 1; pneumoconiosis q/p; six zones; 1/1; healed rib fractures
08 27 1996	DX 23A	James R. Castle, B	p/q; 6 zones; No large opacities; fractures; Multiple old rib fx on R. Old R clavicle fx.
08 27 1996	DX 26	Young Kim, B, BCR	negative for pneumoconiosis; underexposed film; fractures; Multiple healed fractures, incl. rt clavicle & multiple ribs (rt) Non-specific focal fibrosis in both apices, prob old granulomatous process. hyperinflated lung.
02 19 1997	DX 38	Young Kim, B, BCR	negative for pneumoconiosis; film quality 3 underexposure scapula overlap; fractures; Multiple old fractures, rt ribs & clavicle. focal density in the left apex, probably result of old granulomatous process but cannot rule out mass. Recommend a comparison with old films or CT scan.
02 19 1997	DX 42	Gregory J. Fino, B	negative for pneumoconiosis
02 19 1997	CX 6	Jerome F. Wiot, B, BCR	Acceptable film quality; pneumoconiosis q/p, 6 zones, ½; Category B large opacities in both upper lung fields; fracture of right clavicle ununited; complicated coal worker's pneumoconiosis.
11 19 1997	EX 10	A. Dahhan, B	Film quality 1; negative for pneumoconiosis; rib fractures

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
11 19 1997	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality 1; No significant change has occurred since 8/27/96. There are bilateral small opacities of coal workers' pneumoconiosis of moderate profusion, with bilateral areas of coalescence in the upper zones. There are large opacities in both upper zones whose maximum summed diameter is 45mm indicating category A complicated pneumoconiosis. There are no signs of any interval acute cardiac or pulmonary disease, and specifically no evidence of active or healed tuberculosis.
11 19 1997	CX 4	Robert A. Cohen, B	Film quality 1; pneumoconiosis q/p, 6 zones ½; Category A large opacities; rib fractures
11 19 1997	DX 55	Manu N. Patel	simple pneumoconiosis
11 19 1997	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
11 19 1997	DX 72	E. N. Sargent, B, BCR	q/s; 6 zones; 1/1; no large opacities; fractures; tb; since 9/9/92 the rt upper lobe and left apical progressively larger, uncertain etiology. ? Histo & Tbc. Correlate clinically.
11 19 1997	EX 8	Kirk Hippensteel, B	Film quality 1; pneumoconiosis p/q; six zones; 1/1; rib fractures with pleural bruising; calcified granulomas in LUL
11 19 1997	EX 9	Bruce N. Stewart, B	Film quality 1; pneumoconiosis p/q; six zones; 1/1; ill defined density left apex. Healed rib fractures
03 23 1998	EX 8	Kirk Hippensteel, B	Film quality 1; pneumoconiosis p/q; six zones; ½; rib fractures with pleural bruising and inflamation; calcified granulomas in L apex.
03 23 1998	DX 63	James R. Castle, B	q/s; 3 zones; 0/1; no large opacities; fractures; tb; Previous trauma with R fx clavicle & fx R ribs 3-7. Pleural scar along these ribs from prev. trauma. Old granulomatous disease.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
03 23 1998	DX 64	Paul S. Wheeler, B, BCR	negative for pneumoconiosis; film quality 2; fractures; tuberculosis; Oval 1.2x5 cm mass or fibrosis in posterior lateral portion RUL and 1.5 cm oval mass or fibrosis probably posterolateral subapical portion LUL with few tiny scars and nodules in adjacent periphery both upper lobes and lower left apex compatible with conglomerate TB. Suggest CT Scan to see if masses are calcified. Rarely Rheumatoid lung disase (sic) can give this pattern but tumor is unlikely to involve only upper lobes. Healed fracture right clavicle and few healed right rib fractures. Minimal bilateral anterior diaphragm eventration and focal arteriosclerosis aortic arch. No other abnormality. No evidence of silicosis or coal workers' pneumoconiosis.
03 23 1998	CX 4	Robert A. Cohen, B	Film quality 1; pneumoconiosis q/p, 6 zones 2/1; Category A large opacities; rib fractures
03 23 1998	DX 64	James R. Castle, B	q/s; 3 zones; 0/1; no large opacities; fractures; tuberculosis; Previous trauma with R fx clavicle & fx R ribs 3-7. Pleural scar along these ribs from prev. trauma. Old granulomatous disease.
03 23 1998	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality 1; No significant change has occurred in the appearance of the chest which demonstrates changes of complicated coal workers' pneumoconiosis as previously described in greater detail. There is no evidence of any acute cardiac or pulmonary disease in the interval from the last chest x-ray, and specifically no evidence of active or healed tuberculosis.
03 23 1998	EX 9	Bruce N. Stewart, B	Film quality 1; pneumoconiosis p/q; six zones; 1/0; ill defined density left apex. Healed rib fractures
03 23 1998	EX 10	A. Dahhan, B	Film quality 1; negative for pneumoconiosis; rib fractures
03 23 1998	DX 74	E. N. Sargent, B, BCR	p/s; 6 zones; 1/1; Progressive inflammatory changes both upper lobes ?tbc ?Histo?? no large opacities; fractures; correlate with 2nd hand smoking-Lt promary smoking. Most likely inflammatory changes ?tbc?? fingers Histo; cannot exclude pneumoconiosis without a biopsy. Correlate clinically; correlate with silica?? exposure or other dusts.
03 23 1998	DX 66	Young Kim, B, BCR	negative for pneumoconiosis; film quality 2 underexposure; fractures; Multiple old healed rib old healed fx of rt clavicle. Fibrosis in the rt apex prob healed old tb. Focal density in the left apex, prob old scar but need close ?? to rule out mass.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
03 23 1998	DX 55	Manu N. Patel	pneumoconiosis; Category A bilateral upper zone opacities versus calcified pleural plaques; consider CT Scan of the chest.
03 23 1998	DX 64	William W. Scott, Jr.	negative for pneumoconiosis; film quality 2 underexposure PA; fractures; Minimal peripheral scar upper lungs compatible with healed TB. Many healed rib fractures on right. Healed fracture right clavicle. Probable ill-defined scar left apex; advise 6 mo. follow up to exclude neoplasm.
03 23 1998	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
05 19 1998	DX 75	E. N. Sargent, B, BCR	p/s; 6 zones; cannot evaluate profusion level on ET; no large opacities but chronic inflammatory changes most likely tbc?? Histo?; emphysema ? or second hand smoking; tb or histo
05 19 1998	CX 4	Robert A. Cohen, B	Film quality 1; pneumoconiosis q/p, 6 zones 2/1; Category A large opacities; bilateral large opacities ?? in shape measuring 2.5 - 3 cm ; diffuse bilateral small round opacities.
05 19 1998	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality 1; The mid and upper lung zones demonstrate innumerable small round opacities consistent with coal workers' pneumoconiosis of moderate profusion. Areas of coalescence are present in the posterior segments of both upper lobes and there are also bilateral large opacities in the posterior segments of both upper lobes, the appearance and location of which are characteristic of the conglomerate fibrotic masses of complicated coal workers' pneumoconiosis. The lung bases are relatively spared, and no pleural effusions, pneumonia, or pneumothorax are present. No pathologically enlarged lymph nodes are present in the mediastinum, hila, or axillae. The heart and pericardium are normal in appearance.
11 04 1998	DX 84	A. Dahhan, B	q/q; 2 zones; 0/1; no large opacities
11 04 1998	DX 84	Young Kim, B, BCR	negative for pneumoconiosis; film quality 2 underexposure; fractures; tb
11 04 1998	EX 2	Kirk Hippensteel, B	Film quality not stated. pneumoconiosis p/q 1/1; old rib fractures; a few calcified granulomas, scalloped diaphragms.
11 04 1998	DX 78	James R. Castle, B	q/p; 4 zones; 1/1; no large opacities; fractures; tuberculosis; Previous rib fx R clavicle fx. RUL scars may be due to rib fx or old granulomatous dis.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
11 04 1998	EX 9	Bruce N. Stewart, B	Film quality 1; pneumoconiosis q/q; six zones; 2/1; healed rib fractures
11 04 1998	DX 79	William W. Scott, B, BCR	negative for pneumoconiosis; fractures; tuberculosis
11 04 1998	CX 4	Robert A. Cohen, B	Film quality 1; pneumoconiosis q/p, 6 zones 2/1; Category A large opacities; rib fractures
11 04 1998	CX 1	M. S. Alexander, B, BCR	Cat A; p/q; 2/2; ax; fr; film quality 1; There has been no significant interval change compared to 3/23/98. Changes of complicated coal workers' pneumoconiosis are again demonstrated without evidence of any intervening acute pulmonary infectious or inflammatory processes. Specifically, there is no evidence of tuberculosis.
11 04 1998	EX 1	Gregory Fino, B	Film quality 1; negative for pneumoconiosis; bilateral upper lobe fibronodular changes, elliptic density in right upper zone; the changes could be consistent with tb; a less likely etiology is pneumoconiosis; recommend CT scan.
11 04 1998	DX 79	Paul S. Wheeler, B, BCR	negative for pneumoconiosis; film quality 2; fractures; tuberculosis
11 04 1998	EX 11	Thomas Jarboe, B	Film quality 1; pneumoconiosis p/q 1/1 6zones; no large opacities; rib fractures
04 07 1999	EX 19	William W. Scott, B, BCR	Film quality 2, slight underexposure; negative for pneumoconiosis; Peripheral fibrosis and/or infiltrates upper lungs compatible with Tb, unknown activity. Many healed rib fractures on right. Healed fracture right clavicle.
04 07 1999	EX 23	Young Kim, B, BCR	Film quality 2, underexposure; negative for pneumoconiosis; Focal fibrosis or infiltrates in upper lungs, prob. granulomatous process (Tbc), unknown activity multiple old healed fractures. Rt clavicle & ribs.
04 07 1999	EX 19	Paul S. Wheeler, B, BCR	Film quality 1; negative for pneumoconiosis; 2x4 cm angular mass or scar in posterolateral rul between anterior ribs 2-4, possible 1-2 cm mass or fibrosis in lateral subapical portion lul with focal linear and irregular infiltrate or fibrosis probable few tiny calcified granulomata in lateral rul and lateral subapical portion lul all compatible with TB unknown activity, probably healed. Suggest ct scan to see if masses are calcified which would indicate conglomerate TB. Healed fracture right clavicle and few right ribs. Focal Arteriosclerosis aortic arch and possible minimal obesity. CTR: 14/33 excluding epicardial fat.

Film Date	Exhibit	Physician/qualifications	Interpretation for Pneumoconiosis
10 06 1999	EX 23	Young Kim, B, BCR	Film quality 1; negative for pneumoconiosis; Focal fibrosis or infiltrates in upper lungs, prob. granulomatous process, unknown activity multiple old healed fractures. Rt clavicle & ribs.
10 06 1999	EX 19	Paul S. Wheeler, B, BCR	Film quality 1; negative for pneumoconiosis; angular or oval 4 cm mass or fibrosis in lateral lul between anterior ribs 2-4 and probable 3 cm mass or fibrosis in lateral subapical portion lul between anterior ribs 1-3 compatible with healed TB with possible few tiny adjacent calcified granulomata. Suggest CT scan. Healed fracture right clavicle and few right ribs.
10 06 1999	EX 19	William W. Scott, B, BCR	Film quality 1; negative for pneumoconiosis; Peripheral fibrosis and/or infiltrates upper lungs compatible with Tb, unknown activity. Healed fractures right clavicle and several right ribs.
02 01 2000	EX 19	Paul S. Wheeler, B, BCR	Film quality 2, underexposure; negative for pneumoconiosis; angular or oval 4 cm mass or fibrosis in lateral rul between anterior ribs 2-4 and probable 3 cm mass or fibrosis in lateral subapical portion lul between anterior ribs 1-3 compatible with healed TB with possible few tiny adjacent calcified granulomata. Suggest CT scan. Healed fracture right clavicle and few right ribs.
02 01 2000	EX 23	Young Kim , B, BCR	Film quality 2, underexposure; negative for pneumoconiosis; Focal fibrosis or infiltrates in upper lungs, prob. granulomatous process, unknown activity multiple old healed fractures. Rt clavicle & ribs.
02 01 2000	CX 3	Manu N. Patel	Mild to moderate profusion of small opacities throughout all lung zones is revealed, associated with bilateral stable, poorly defined, non-calcified Category A large opacities in the upper lung zones, classifiable as complicated pneumoconiosis. There is no consolidation or obvious enlarging lung mass.
02 01 2000	EX 19	William W. Scott, B, BCR	Film quality 2; negative for pneumoconiosis; Peripheral fibrosis and/or infiltrates upper lungs compatible with Tb, unknown activity. Healed fractures right clavicle and several right ribs.

CT SCANS:

Scan Date	Exhibit	Physician/qualifications	Interpretation
05 19 1998	DX 60 DX 64	Paul S. Wheeler, B, BCR	**CT SCAN:** Mimimal emphysema; Minimal healed TB; No evidence of silicosis or CWP
05 19 1998	DX 60 DX 64	William W. Scott, B, BCR	**CT SCAN:** Healed TB
05 19 1998	EX 6	Young Kim, B, BCR	**CT SCAN:** 2 cm irregular nodule in the periphery of Rt. UL with several adjacent small nodules seen. 2 cm nodule appears to have central calcification. Also 2 cm. irregular mass is seen in the left upper lobe, but no definite calcification is seen. Above findings in both upper lobes are compatible with old healed TB.
05 19 1998	EX 13	Dr. Elliot Fishman	**CT SCAN:** Ill defined nearly 2 cm lesion in RUL and 2.5 to 3 cm lesion in LUL; inflammatory process such as tuberculosis or histoplasmosis; pneumoconiosis was considered, but typically the masses are more central and there is more scarring and fibrosis; this probably represents an inflammatory etiology like TB.
05 19 1998	DX 55	Manu N. Patel	**CT SCAN:** Mild profusion of small opacities throughout all lung zones is revealed, associated with bilateral upper zone category A, ill defined, lobulated, and minimally spiculated large opacities localized in the upper lung zones, classifiable as complicated pneumoconiosis; absence of pleural effusion or pleural thickening
05 19 1998	CX 1	Michael S. Alexander, BCR, B, BCN[10]	**CT SCAN:** Complicated Coal Worker's Pneumoconiosis, category A, p/q, 2/2, ax, fr. No evidence of healed tuberculosis.
05 19 1998	CX 4	Cohen, B	**CT SCAN:** bilateral large opacities polygonal in shape, measuring between 2.5 and 3.0 cm in the largest dimensions. Diffuse bilateral small round opacities were also noted. This study is consistent with complicated and simple coal worker's pneumoconiosis.

PULMONARY FUNCTION TESTING:

Date	Exhibit	FVC	FEV_1	MVV	Comment
02 05 1980	DX 33-193	4.23	3.16	103	Lack of maximum effort noted
06 10 1985	DX 33-264	3.78	2.67	65	No bronchodilators; cooperation & understanding good
09 08 1986	DX 33-191	4.23	2.95	127	

[10] Dr. Alexander is Board Certified in Nuclear Medicine.

Date	Exhibit	FVC	FEV_1	MVV	Comment
02 09 1988	DX 33-130	3.83	2.73	109	Minimal obstruction ventilatory impairment, Maximum breathing capacity is within normal limits.
02 19 1996	DX 35	3.45 3.49	2.24 2.25	92 97	Pre-bronchodilator Post-bronchodilator Valid studies; spirometry show very mild airway obstruction. Lung volumes are essentially normal. There is no restriction. Diffusion is normal.
08 09 1996	DX 9	3.48	2.45	86.6	No bronchodilators; cooperation & understanding good
05 18 1998	DX 55	3.36 2.53	2.37 1.99	3.82 3.41	Pre-bronchodilator Post-bronchodilator Mild obstructive disease; obstructive disease confirmed by increased residual volume; Moderate decrease in Dsb
11 04 1998	DX 78	2.80 3.69	2.32 2.56	103 83	Pre-bronchodilator Post-bronchodilator Pre-bronchodilator spirometry is not valid because of variable effort. Post-bronchodilator spirometry is valid and is essentially normal. Lung volumes show gas trapping. There is no restriction. Diffusion is normal.
12 01 1999	CX 3	3.26 3.20	2.33 2.41		Pre-bronchodilator Post-bronchodilator

ARTERIAL BLOOD GAS TESTING:

Date	Exhibit	$pC0_2$	$p0_2$	Comment
06 10 1985	DX 33-256	32 34	62 78	Resting values Exercise values
05 21 1987	DX 33-209	33	63	During hospital admission for rib fractures
09 10 1987	DX 33-203	34	63.1	Moderate hypoxemia Invalid study, see DX 33, pages 167-187.
09 11 1987	DX 33-206	33.9	65.6	Resting values
02 19 1996	DX 35	33.7	74	Resting values; resting ABG's are normal, carboxyhemoglobin level is normal. Mild obstructive airway disease
08 09 1996	EX 11	36.6	73.8	Resting values
05 18 1998	DX 55	35.8	65	
11 04 1998	DX 78	35.1	67	Resting ABG's are at lower range of normal for age. Carboxyhemoglobin level is normal.
12 01 1999	CX 2	32	57	
02 01 2000	CX 2	36.6	68	

MEDICAL REPORTS:

Dr. D. L. Rasmussen examined the Claimant at the request of the Department of Labor on June 12, 1985 (DX 33 pages 259-263). Dr. Rasmussen completed an employment history of 34½ years coal mine work, family and health histories, and a smoking history of 1pack of cigarettes per day for 8 years. He noted present symptoms of cough, dyspnea, chest pain and orthopnea, and performed pulmonary function and arterial blood gas studies. He diagnosed coal workers' pneumoconiosis with minimal impairment.

Drs. D.B. MacCallum and J.L. Leef reported that the Claimant was examined on September 8, 1986. They reported a 35½ year history of coal mine employment, that Claimant quit smoking 30 years earlier from ½ to 1 pack per day for 8 years. The diagnosis was occupational pneumoconiosis with no change in pulmonary impairment since 1980. (DX 33-197).

Claimant was admitted to Raleigh General Hospital for rib and clavicle fractures on May 21, 1987, and was discharged on May 23, 1987. (DX 33-208, 209-211) During his stay he was attended by Dr. Richard G. Starr who performed a physical examination, blood work, blood gas study, chest x-ray and EKG. Dr. Starr diagnosed rib fractures, fracture of the right clavicle, pulmonary emphysema and coal workers' pneumoconiosis.

Dr. George L. Zaldivar examined the Claimant at the request of the Employer on February 22, 1988 (DX 33-143-165). He noted that Claimant complained of shortness of breath, noted a smoking history of 1 pack per day for 12 years and 35½ years of coal mine work. Dr. Zaldivar made physical findings that the Claimant was 67 inches tall, performed a pulmonary function study and an arterial blood gas study, performed a chest x-ray and his physical examination. He diagnosed that Claimant has mild irreversible airway obstruction, normal diffusing capacity, simple pneumoconiosis, and normal blood gases. He opined that "From the pulmonary standpoint Mr. Cooper is capable of performing all mine work for which he has been trained. The shortness of breath of which he complains could not be the result of pulmonary problems because none exists."

Dr. Gregory J. Fino reviewed documents supplied by Employer regarding the proper calibration procedure for a Radiometer of America ABL-3- Acid Base Analyzer. (DX 33-167-187) Dr. Fino notes that this particular instrument does not automatically measure, record or scale the actual barometric pressure, but that such must be input for proper calibration. He explains that because the barometric pressure was set improperly at 740 mmHg, for the Tri-County Pulmonary Laboratory in Beckley, West Virginia, all arterial blood gas studies produced at this setting are invalid. Employer also submitted a letter from the Director of the Tri-County Pulmonary Laboratory in Beckley, West Virginia, acknowledging that the barometric pressures were improperly set at 740 mmHg from March 1, 1983 to January 4, 1988. (DX 33-167-187).

Dr. George L. Zaldivar reviewed medical records submitted to him by the Employer. Dr. Zaldivar reports that he reviewed his own records (2/17/1988 exam) as well as blood gas reports by Drs. Ahmed and Floresca. He states that this new information does not alter his opinion as given in his report dated 2/22/88. (DX 33-199).

Dr. Gregory J. Fino reviewed medical records provided by Employer on February 14, 1989. (DX 33-116). Dr. Fino opined that Claimant had early x-ray evidence of pneumoconiosis, but had no respiratory impairment.

Dr. Mohammed I. Ranavaya examined the Claimant at the request of the Department of Labor on August 9, 1996 (DX 10). He noted an employment history of 35 years underground coal mining. He completed a medical history; history of smoking cigarettes (amount not stated) from 1959 through 1964; history of shortness of breath and chest pain; and performed a physical examination. Dr. Ranavaya also performed a chest x-ray, pulmonary function study, arterial blood gas study and EKG. He diagnosed coal workers pneumoconiosis - complicated - based on a 35 year long history of occupational exposure to dust in coal mining and radiological evidence; and exertional angina pectoris and hypertension, based upon history. He opined that the cause of Claimant's cardiopulmonary diagnoses is "Occupational exposure to dust in coal mining for 35 years." Regarding impairment due to chronic respiratory or pulmonary disease, he opined that Claimant's impairment was "Mild as reflected by pulmonary function studies." (DX 10).

Dr. Ralph T. Shipley, by letter dated February 6, 1997, expands upon his x-ray readings of films dated 7/28/1995 and 8/27/1996. He opines that "There is irregular nodular density in both apices, right greater than left, that is unchanged since 7/28/1995. There is no background of small nodular opacities. The remainder of the lungs is clear." His impression was "Stable biapical nodular opacities. Because of the lack of background of small opacities, these most likely represent healed granulomatous disease such as histoplasmosis or tuberculosis rather than complicated coal workers' pneumoconiosis. (DX 28).

Dr. Harold B. Spitz, by letter dated February 21, 1997, expands upon his x-ray readings of films dated 7/28/1995 and 8/27/1996. He opines that "There are old rib fractures on the right and an old fracture of the midright clavicle. The heart and aorta are normal. There are some linear strands in both upper lobes and there is some associated opacity in both uppe (sic) lobes consistent with some infiltrate. This infiltrate does not change in appearance between the two studies. The remainder of the lungs is clear and there is no pleural disease." His impression was "No evidence of pneumoconiosis. Bilateral upper lobe disease consistent with previous granulomatous disease such as tuberculosis or histoplasmosis." (DX 29).

Dr. James R. Castle examined the Claimant at the request of Employer on February 19, 1997 (DX 35). In addition to his physical examination, Dr. Castle administered a chest x-ray, pulmonary function study, arterial blood gas study, and an ECG, and reviewed additional medical evidence provided to him. He also noted an employment history of 35 years in the mines and a smoking history[11] of:

> He indicates that he only smoked from 1958 to 1993 and he smoked one pack per day. He states that he did not start smoking as a younger man. This would give him a 35 pack-year smoking history."

[11] This smoking history is grossly inconsistent with the 8 year smoking history appearing multiple times in the record.

Dr. Castle diagnosed simple pneumoconiosis with no physiologic impairment, mild asthmatic bronchitis (tobacco smoke induced), mild airway obstruction (tobacco smoke induced). He opined that Claimant is not permanently and totally disabled as a result of the simple coal workers' pneumoconiosis that is present radiographically (DX 35). Dr. Castle testified July 25, 1997, by deposition regarding his examination. (DX 44).

Dr. Gregory Fino reviewed x-ray films dated 7/28/95, 8/9/96, 8/27/96, 2/19/97 and concluded,

> There are bilateral upper lobe fibronodular changes. There is an elliptic density in the right upper zone. The changes could be consistent with tuberculosis or, less likely, with coal workers' pneumoconiosis. I would suggest that a CT scan be performed. I classified these films as 0/0.

(DX 42).

Dr. Gregory Fino reviewed Claimant's medical records and concluded that:

> In my report to dated 2/14/89, I concluded that this man had no respiratory impairment or respiratory disability. When I reviewed a series of chest x-rays earlier this year, I felt that pneumoconiosis was not present. However, even if I assume that pneumoconiosis is present, I still believe that this man does not suffer a respiratory impairment that would prevent him from returning to his last mining job. I believe that his symptoms are related to smoking.

(DX 42).

Dr. George L. Zaldivar reported on July 10, 1997 that he had reviewed medical records provided to him by Employer. Based upon his review of the records, he opined that there is no evidence of coal workers' pneumoconiosis; there is mild respiratory impairment due to 35 pack years of cigarette smoking and also to his mine work; there is no evidence of any disabling pulmonary impairment and that Claimant is capable of performing not only his usual coal mine work but also arduous manual labor. (DX 42).

Dr. Thomas M. Jarboe reported on July 11, 1997 that he had reviewed medical records provided to him by Employer. Based upon his review of the records, he opined that there is x-ray evidence of simple pneumoconiosis, but not complicated pneumoconiosis; that Claimant has minimal or no respiratory impairment; that Claimant is not totally and permanently disabled from his regular coal mine work. (DX 42 and 43).

Dr. C. Garretson reported that he saw the Claimant on July 29, 1997, at which time the Claimant showed him a copy x-ray interpretations by Dr. Harold Spitz, that the Claimant does not have pneumoconiosis. Dr. Garretson stated that such was contrary to his opinion; that it was his opinion that Claimant has pneumoconiosis which has progressed from simple to complicated, and that the Claimant would not be able to resume work as a coal miner. (DX 41).

Dr. A.M. Behnam apparently saw the Claimant at the Southern West Virginia Clinic on February 27, 1998 and diagnosed "Supra pubic pain, possible cystitis." (DX 55)

Dr. Maria Boustani saw the Claimant at the Southern West Virginia Clinic on March 23, 1998, for shortness of breath and pain under shoulder blades. Largely illegible handwritten notes mention the word "pneumoconiosis." Dr. Boustani's typewritten report indicates that Claimant has a history of gout, pneumoconiosis and hypertension. She performed a physical examination and chest x-ray and EKG, and reported that the x-ray and EKG were normal. Dr. Boustani indicated that a pulmonary function study would be subsequently performed. Subsequent treatment notes from Dr. Boustani indicate treatment for a history of pneumoconiosis; indicate that a CT scan of his chest was performed, which did not show any significant problems except for a possible cyst in his kidney; and noted significant chronic obstructive pulmonary disease. (DX 55).

Handwritten clinic notes from the Southern West Virginia Clinic dated 5/18/98 indicate that a "PFT and ABG were performed on that date. (DX 55).

Dr. James R. Castle reported on March 23, 1999, that he examined the Claimant on November 4, 1998 and reviewed medical records provided by the Employer. He diagnosed simple pneumoconiosis with no impairment, no significant respiratory impairment from any cause; asthmatic bronchitis; gout and rib and clavicle fractures. Dr. Castle opined that "It is my opinion that the pneumoconiosis present has not caused Mr. Cooper permanent and total disability. Mr. Cooper does retain the respiratory capacity to perform his usual coal mining employment duties should he desire to do so. Mr. Cooper is capable of performing any and all jobs in the mining industry for which he has received training. He is not permanently and totally disabled as a result of any pulmonary process arising from his coal mining employment or from any other disease." (DX 78).

Dr. Maria Boustani reported on April 7, 1999 that she had seen the Claimant for his pulmonary problems on a regular basis since 3/23/98. She noted that the Claimant has been diagnosed as having complicated pneumoconiosis by Dr. Patel, a B reader, and that he would be treated for his pneumoconiosis. (DX 81).

Dr. Thomas M. Jarboe reviewed medical records submitted to him by Counsel for Employer on September 2, 1999. He opined that the Claimant does have radiographic evidence of simple pneumoconiosis, but does not have complicated pneumoconiosis. He opines that the Claimant does not have any significant respiratory impairment, and that the Claimant is not totally and permanently disabled from a respiratory standpoint from performing his regular coal mining work or work requiring similar effort. (EX 3).

Dr. Gregory J. Fino reviewed medical records submitted to him by Counsel for Employer on September 6, 1999. Dr. Fino opined that while there is chest x-ray evidence of simple pneumoconiosis, his reading of chest x-rays was negative. He states that there is no evidence of complicated pneumoconiosis, and there is no pulmonary impairment or disability. (EX 4).

Dr. Maria Boustani reported on December 1, 1999 that the Claimant was followed at the Appalachian Regional Healthcare Clinic for his pneumoconiosis. She states that he has complicated pneumoconiosis with shortness of breath on exertion and even occasionally at rest. She states that his pulmonary function tests have shown only mild obstructive airway disease, but

has severe hypoxemia. (CX 3).

Dr. Maria Boustani reported on February 1, 2000 that she saw Mr. Cooper for follow-up on his complicated pneumoconiosis. He was prescribed medication and told to follow-up in 5 months or earlier as needed. (CX 3).

Dr. Maria Boustani reported on February 18, 2000 that she saw Mr. Cooper on complaints of shortness of breath while walking in his yard, which lasted for ½ hour. He was prescribed Zoloft to rule out panic disorder and was told to come back in a month. (CX 3).

Dr. A. Dahhan reviewed medical records submitted to him by Counsel for Employer on March 1, 2000. Dr. Dahhan opined that after reviewing the medical records, it is his opinion that the Claimant has radiological findings sufficient to justify the diagnosis of simple pneumoconiosis; that he no findings to indicate complicated pneumoconiosis; and that the Claimant has no evidence of total or permanent pulmonary disability, although he does have arthritis, angina, gout and panic attacks. (EX 14).

Dr. Bruce N. Stewart reviewed medical records submitted to him by Counsel for Employer on March 9, 2000. Dr. Stewart opined that after reviewing the medical records, it is his opinion that Mr. Cooper has evidence for simple coal workers' pneumoconiosis. As to complicated pneumoconiosis, Dr. Stewart states that he agrees with Dr. Jarboe's assessment that the CT scan shows central calcification, which is a hallmark of old granulomatous disease. He states that it is his opinion that the Claimant does not have any significant pulmonary or respiratory impairment, and that he is not totally and permanently disabled from a respiratory standpoint. He states that his opinions would not change if coal workers' pneumoconiosis were found to be present. (EX 16).

Dr. Kirk E. Hippensteel reviewed medical records submitted to him by Counsel for Employer on March 13, 2000. Dr. Hippensteel opined that the Claimant has simple pneumoconiosis, and granulomatous disease which is not consistent with complicated pneumoconiosis, and has asthmatic bronchitis. He opines that the Claimant does not have respiratory impairment that would keep him from working at his job, which would include heavy labor. (EX 15).

Dr. A. Dahhan reviewed medical records submitted to him by Counsel for Employer on April 6, 2000. Dr. Dahhan opined that after reviewing the medical records, it remains his opinion that the Claimant's x-rays do not reveal enough opacities to justify a diagnosis of simple pneumoconiosis; that he does not find sufficient objective data to justify a diagnosis of complicated pneumoconiosis; and that the Claimant has no evidence of total or permanent pulmonary disability, although he does have arthritis, angina, gout and panic attacks. (EX 17).

Dr. Gregory J. Fino reviewed medical records submitted to him by Counsel for Employer on April 15, 2000. Dr. Fino opined that after reviewing the medical records, he found no evidence of an abnormality in Claimant's pulmonary system related to coal mine dust inhalation, and that such is true even if it were assumed that he has medical or legal pneumoconiosis. (EX 18).

Dr. Robert A. C. Cohen reported that he reviewed the Claimant's medical records provided by Claimant's Counsel on April 20, 2000. (CX 4). He opined that the Claimant suffers from coal workers' pneumoconiosis, shortness of breath and significant dyspnea on exertion. He states that he has had pneumoconiosis since 1985, has no evidence of tuberculosis, no evidence of histoplasmosis or any other granulomatous disease. He opined that the Claimant has Category A complicated pneumoconiosis. As to impairment, Dr. Cohen opines that Claimant has moderate diffusion impairment in conjunction with gas exchange abnormalities, and mild obstructive lung disease. He concludes that the Claimant does not have the pulmonary capacity to return to his coal mine employment.

Dr. Thomas M. Jarboe reviewed medical records submitted to him by Counsel for Employer on April 21, 2000. He opined that the Claimant does have radiographic evidence of simple pneumoconiosis, but does not have complicated pneumoconiosis. He opines that the Claimant does not have any significant respiratory impairment, and that the Claimant is not totally and permanently disabled from a respiratory standpoint from performing his regular coal mining work or work requiring similar effort. (EX 21).

Dr. Steven M. Koenig reviewed medical records submitted to him by Counsel for Employer on April 24, 2000. Dr. Koenig concluded that the Claimant's 35 years of dust exposure in coal mining to cause dust-induced lung disease. He opined that "Because of the characteristics of the pulmonary opacities, the very slow, steady progression of the large upper lobe opacities over many years, the absence of systemic symptoms such as fever, loss of appetite, fatigue and weight loss, the absence of a personal or family history of tuberculosis as well as the absence of exposure to tuberculosis or any other granulomatous infection, complicated CWP is the most likely cause of Mr. Cooper's Chest X-ray abnormalities." He further opined that the Claimant has a mild (10-25%) impairment of the whole person; that his impairment is caused by coal dust exposure that resulted in complicated CWP. Finally, he states that due to the exertion required in his last job in the mines, his impairment renders him totally disabled from performing his prior occupation in the coal mines. (CX 5).

Dr. Kirk E. Hippensteel reviewed medical records submitted to him by Counsel for Employer on April 25, 2000. Dr. Hippensteel opined that the records reviewed did not change his March 13, 2000 opinion that the Claimant does not have findings of permanent impairment from any disease including the simple coal workers pneumoconiosis and granulomatous disease that he has on x-ray. He states that the Claimant does not have any fixed irreversible impairment to his lung function, and the fact that he can have normal function at times is contra to a diagnosis of complicated pneumoconiosis. (EX 22).

Dr. Bruce N. Stewart reviewed medical records submitted to him by Counsel for Employer on April 25, 2000. Dr. Stewart opined that after reviewing the medical records, it remains his opinion that there is insufficient evidence to justify a diagnosis of simple coal workers' pneumoconiosis. He states that it remains his opinion that the Claimant does not have any significant pulmonary or respiratory impairment, and that he is not totally and permanently disabled from a respiratory standpoint. (EX 20).

Dr. James R. Castle reviewed medical records submitted to him by Counsel for Employer

on April 27, 2000. Dr. Castle opined that based upon his review of records, that the Claimant does have radiographic evidence of simple pneumoconiosis. However, he was of the opinion that the Claimant is not permanently and totally disabled as a result of the pneumoconiosis that is present radiographically. He states that it is possible that the Claimant may be disabled as a whole man, because of medical problems, but that he retains the respiratory capacity to perform his usual coal mine employment duties. (EX 23).

Request for Modification of the Denial of Claimant's Duplicate Claim

Mistake in a Determination of Fact

As indicated, this case involves a request for modification under § 725.310 of the regulations, which provides for modification of a denial on the grounds of mistake in a determination of fact or change of conditions. The United States Supreme Court, in *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971)[12], has indicated that all evidence of record should be reviewed in determining whether "a mistake in a determination of fact" has been made and the Court stated that, on modification, the fact-finder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *See also Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Kovac, supra; Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987). In accord, see *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).[13]

One of the issues considered in the May 5, 1998 denial of Claimant's duplicate claim, was whether the Claimant had demonstrated a material change of conditions by that establishing that he had developed complicated pneumoconiosis. (DX 47 at 8-9). In finding complicated pneumoconiosis had not been established, Judge Levin noted that the record before him contained 2 x-ray readings by B readers (Drs. Gaziano and Ranavaya) (DX 13,14) who opined that the Claimant has evidence of complicated pneumoconiosis. To the contrary, it was noted that Drs. Francke, Scott and Wheeler (DX 27), all of whom are B readers and Board Certified Radiologists, and Drs. Fino and Castle (DX 42 and 24), both of whom are B readers, found no evidence of complicated pneumoconiosis in the same x-ray (8/9/1996 film). Greater weight was accorded the opinions of the three physicians who were certified as B readers and as Board Certified Radiologists. Therefore, it was held that x-ray evidence did not demonstrate complicated pneumoconiosis.

In the record which appears before me, there are two additional interpretations of the

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[12] The O'keefe decision involved interpretation of § 22 of the Longshore Act, which is the basis for 20 C.F.R. § 725.310, due to the incorporation of § 22 into the Black Lung Benefits Act.

[13] The "mistake in a determination of fact" analysis requires a re-examination of the entire record. Here, the analysis is being performed by this Administrative Law Judge reviewing the decision of a different, sitting Administrative Law Judge. This practice raises the specter of serial "judge shopping" until a desired result is reached, unless the case is considered by the original Judge. However, no case law currently exists which would require reconsideration of the case by the original, authoring judge. Therefore, when a request for modification is filed, the case is assigned at random, resulting in this anomaly.

same August 9, 1996 x-ray, by Dr. Young Kim (DX 29) and Dr. Jerome F. Wiot (CX 6). Both of these physicians are dually certified as B readers and Board Certified Radiologists. Based upon the date of submission of the opinion of Dr. Kim, it appears that such was part of the record considered by Judge Levin, but was not referenced in his opinion.

The opinion of Dr. Wiot was submitted in the current proceedings as a Claimant exhibit. Dr. Wiot read the x-ray as revealing that the Claimant has Category B large opacities in both upper lung fields as well as simple pneumoconiosis ½ in all six zones.[14] Dr. Wiot's curriculum vitae, which appears of record in CX 6 clearly indicates that he is a highly qualified and respected radiologist. Indeed Dr. Wiot was a member, from 1969 and continuing, of the American College of Radiology Task Force on Pneumoconiosis, which is the body requested by NIOSH to develop the B reader program. Due to Dr. Wiot's dual certification as a B reader and Board Certified Radiologist, and due to his role in advising NIOSH in development of the B reader program, his opinion is accorded great weight in evaluating the conflicting x-ray readings of the August 9, 1996 film.

Additionally, even Dr. Wheeler, who read the August 9, 1996, film as showing no large opacities, did find that the Claimant had an "Oval 1x2 CM mass or scar or pleural fibrosis in lateral portion right upper chest between anterior ribs-2-3." Dr. Wheeler attributed the mass to TB, stating that "Peripheral upper lobe disease favors TB over pneumoconiosis." However, this opinion as to the cause of the mass does not negate its compatibility with an opacity of 1 cm or greater as required by § 718.304(a). It is also equivocal as to the cause of the mass, as is indicated by his opinion that "Peripheral upper lobe disease favors TB over pneumoconiosis."

I recognize that Dr. Gaziano, who also found Category A large opacities, also diagnosed "bilateral apical density rule out T.B. (Tuberculosis) Need see M.D. " However, there is no evidence in the record to indicate that the Claimant has ever been diagnosed with or treated for tuberculosis.

Further, I note that the opinions of Dr. Wheeler, Dr. Fino and Dr. Scott, that the Claimant does not have even simple pneumoconiosis, are inconsistent with the findings made by Judge Kichuk, affirmed by the Benefits Review Board, and not disturbed herein, that the Claimant suffers from simple pneumoconiosis.

In reconsidering the x-ray readings of the August 9, 1996 film, when the additional opinion of Dr. Wiot is added, I find that a mistake was made in the determination that the film did not demonstrate the presence of large opacities. The reason cited for according less weight to the opinions of Dr. Gaziano and Dr. Ranavaya was that they were not Board Certified Radiologists. This is not true of Dr. Wiot, and indeed, his credentials are superior to the other Board Certified

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[14] It is unknown where this opinion was when the case was originally decided by Judge Levin, but it clearly was not part of his record. Instead this x-ray reading was only produced to the Claimant as result of an order to compel discovery issued in this case. Employer was ordered to produce the names of any doctors' to whom Employer sent Claimant's x-rays and CT scans. The Employer was not ordered to produce the actual medical reports due to its claim of privilege in its preparation for hearing. Nevertheless, the opinion of Dr. Wiot was included in Employer's response, and was admitted into the record.

Radiologists, as he was instrumental in developing the B reader program itself. Therefore, upon further reflection of the readings of the August 9, 1996, x-ray, giving great weight to the opinion of Dr. Wiot, I find that the film is positive for complicated pneumoconiosis.

Accordingly, I find that a mistake was made in a determination of fact within the meaning of 20 C.F.R. 725.310, and the Claimant's request for modification must be granted. Therefore, the decision to deny the duplicate claim under § 725.309 will be reconsidered. This does not mean that the Claimant is entitled to Black Lung Benefits at this juncture, but only that this Administrative Law Judge must "step back into the shoes" of the prior Judge [Levin] and consider the duplicate claim for benefits. In so doing, all evidence of record will be considered, including the evidence newly submitted in the request for modification proceedings.[15]

Reconsideration of the Claimant's Duplicate Claim

Since the Claimant's original claim for federal black lung benefits was finally denied on March 28, 1991 (DX-33 at 4), and since his duplicate claim was filed more than one year later, on July 8, 1996, the provisions of 20 C.F.R. § 725.309 apply.

The burden of proof rests with the Claimant to establish a material change of conditions pursuant to § 725.309, since his original claim for black lung benefits was denied on September 12,1989. The basic premise underlying § 725.309 is that pneumoconiosis is a progressive and irreversible disease. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997); *Lane Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1992); *Barnes v. Mathews*, 562 F.2d 278, 279 (4th Cir. 1977) ("pneumoconiosis is a slow, progressive disease often difficult to diagnose at early stages"). Under the amended regulations, it is noted that § 718.201(c) provides that "'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c) (Dec. 20, 2000).

In denying the earlier claim, Judge Kichuk found that the Claimant had worked for 32 years in the coal mines, with his last employment being for the Employer. He also held that the Claimant established that he suffered from pneumoconiosis caused by coal mine work and that these issues were not in dispute. He weighed the pulmonary function evidence and found that it did not meet the criteria for establishing total disability. He weighed the arterial blood gas evidence and found that it did meet the criteria for establishing total disability. He then weighed the physicians reports and found that they did not establish total disability. Finally, he weighed all of the medical evidence together and found that the Claimant had not established total disability. Therefore, the claim was denied. However, in denying the claim, Judge Kichuk did not reference any evidence of complicated pneumoconiosis.

The Benefits Review Board considered the opinion of Judge Kichuk on appeal and affirmed the denial of benefits. Again, there was no reference to complicated pneumoconiosis.

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[15] Because of the finding of mistake in a determination of fact, it is not necessary to consider whether there has been a change of conditions since May 5, 1998. I do note that in addition to the opinion of Dr. Wiot, the record now contains over 100 x-ray readings, with 22 opinions of complicated pneumoconiosis.

Since the original claim was denied, the record now contains many opinions that the Claimant suffers from complicated pneumoconiosis. Therefore, I will first consider whether complicated pneumoconiosis is established under § 718.304.

Complicated pneumoconiosis

Under § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, if the miner is suffering from complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, or by an autopsy or biopsy which yields evidence of massive lesions in the lung, or by other means which could reasonably be expected to yield the same results. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

In the instant case, there are multiple x-ray readings which indicate the presence of large opacities of complicated pneumoconiosis in the Claimant's lungs. The earliest x-ray reading for complicated pneumoconiosis was by Dr. E.N. Sargent of the October 1, 1985 x-ray.[16] Therefore, I find that the x-ray evidence is negative for complicated pneumoconiosis prior to October 1, 1985.

In all, there are a total of 11 x-rays (see summary above) taken of the Claimant's chest have been read as revealing large opacities of at least category A, with some readings as category B opacities. Those 11 films were taken on October 1, 1985, September 9, 1992, July 28, 1995, August 9, 1996, August 27, 1996, February 19, 1997, November 19, 1997, March 23, 1998, May 19, 1998, November 4, 1998, February 1, 2000. These readings are all by highly qualified physicians who are either B readers or Board Certified Radiologists or both.[17] As indicated earlier, Dr. Jerome F. Wiot read the August 9, 1996 film as revealing Category B large opacities. Similarly, Dr. Wiot read the July 28, 1995, August 27, 1996, and February 19, 1997 films as revealing Category B large opacities.

For each of these films, there are also opinions from highly qualified physicians, including B readers and Board Certified Radiologists, who did not find that the Claimant has large opacities. However, many of these readings include opinions that the Claimant does not even have simple pneumoconiosis, a fact which has been established in this case since the decision of Judge Kichuk, in which the Employer stipulated that the Claimant has pneumoconiosis caused by coal mine employment. Because theses opinions are not consistent with the finding that the Claimant does even have simple pneumoconiosis, I accord less weight to the negative x-ray readings by Drs. Paul Wheeler, William Scott, Young Kim, Gregory Fino, Ralph Shipley, Harold

[16] As indicated, the record considered by Judge Kichuk and the Board contained no references to complicated pneumoconiosis. While the record now contains readings of x-ray films older than the case considered by Judge Kichuk, all of those readings were performed by physicians after the prior case was decided.

[17] One physician who saw large opacities, Dr. Manu Patel, is not a B reader or Board Certified Radiologist.

Spitz, A Dahhan, and James Castle.

Additionally, a number of physicians have read films as revealing tuberculosis. However, there is no medical evidence that the Claimant has ever been tested as positive for tuberculosis, or that he has ever been treated for tuberculosis. Therefore, the opinions that the masses seen on the Claimant's chest x-ray could be tuberculosis are speculative, and are not consistent with the absence of any other medical evidence that the Claimant has, or has ever had, or has ever been treated for tuberculosis.

I also note that some readings by physicians who opine that the Claimant does not have large opacities, also include readings that he has a "mass compatible with fibrosis" which is larger than 1 cm. Such findings are, in fact, consistent with a diagnosis of complicated pneumoconiosis within the definition in § 718.304. For example, Dr. Wheeler read the February 19, 1996 film as showing an oval 1.5 x 4-5cm mass compatible with fibrosis (DX 37). This diagnosis, despite Dr. Wheeler's opinion that the Claimant does not have pneumoconiosis, is a diagnosis of a large opacity of at least category A size.

Finally, I also note that the record contains readings of a CT Scan performed of the Claimant's chest on May 19, 1998. Employer argues that the "majority" of these readings find evidence of healed tuberculosis but not complicated pneumoconiosis, citing opinions by Drs. Wheeler, Scott, Kim, Fishman and Sargent.[18] (Employer 9/5/2000 brief at 4).

As noted with respect to the x-ray opinions, none of these physicians have acknowledged that the Claimant even has simple pneumoconiosis. Drs. Paul Wheeler and William Scott both read the CT Scan as negative for pneumoconiosis, but revealing tuberculosis. Again, the existence of simple pneumoconiosis due to coal mine employment is established in this case.

Additionally, Dr. Young Kim read the scan as revealing a "2 cm irregular nodule in the periphery of Rt. UL with several adjacent small nodules seen; 2 cm nodule appears to have central calcification; also 2 cm. irregular mass is seen in the left upper lobe, but no definite calcification is seen; above findings in both upper lobes are compatible with old healed TB." (EX 6). Dr. Elliott Fishman saw an "ill defined nearly 2 cm lesion in RUL and 2.5 to 3 cm lesion in LUL; inflammatory process such as tuberculosis or histoplasmosis; pneumoconiosis was considered, but typically the masses are more central and there is more scarring and fibrosis; this probably represents an inflammatory etiology like TB." (EX 13).

Upon consideration, I find that these opinions by Dr. Kim and Dr. Fishman, are the equivalent of an x-ray opinion that the Claimant has opacities of at least 1 cm in size, if not greater, within the meaning of § 718.304(c).

In contrast, Drs. Patel, Alexander and Cohen, read the same CT Scan as revealing that the Claimant suffers from complicated pneumoconiosis. Dr. Alexander is the only physician who read the scan, who is Board Certified in Nuclear Medicine as well as being Board Certified in

[18] The opinion of Dr. Sargent referenced by the Employer at DX 75 is an x-ray reading.

Radiology and as a B reader. Dr. Alexander found the CT scan revealed "Complicated Coal Worker's Pneumoconiosis, category A, p/q, 2/2, ax, fr. No evidence of healed tuberculosis."

Upon consideration of the CT Scan evidence, I find that the preponderance of the evidence establishes the existence of complicated pneumoconiosis, and the equivalent of an x-ray opinion that the Claimant has opacities of at least 1 cm in size, if not greater, within the meaning of § 718.304(c).

Further, upon consideration of all of the evidence of record, I find that the preponderance of the evidence establishes that the Claimant has x-ray evidence of large opacities of complicated pneumoconiosis, of at least category A. As such, I find that the Claimant is entitled to the irrebuttable presumption of § 718.304, that he is totally disabled due to pneumoconiosis. As indicated earlier, it has been established that the Claimant's pneumoconiosis is caused by his 32 years of coal mine work.

Therefore, I find that the Claimant has established a material change of conditions following the denial of his claim by Judge Kichuk on September 12, 1989. As the presumption of § 718.304 applies, the Claimant is entitled to federal black lung benefits.

As indicated above, the earliest date that the Claimant was diagnosed with complicated pneumoconiosis was October 1, 1985. However, as this decision is based upon a finding of a material change of conditions since the initial claim was denied, I find that the Claimant is entitled to federal black lung benefits as of September 12, 1989.

ORDER

The Employer, Westmoreland Coal Company, is hereby ORDERED to:

1. Pay to the Claimant, Charles Edward Cooper, all federal black lung benefits to which he is entitled, commencing October 1, 1985, as augmented by his dependent wife, Norma Jean Cooper.

2. Pay for or otherwise provide all medical benefits to which the Claimant is entitled.

3. The benefits paid hereunder shall be offset by virtue of any awards to the Claimant for workers' compensation for occupational disease by the State of West Virginia.

ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein because no application has been received from Counsel. A period of thirty (20) days is hereby allowed for Claimant's Counsel to submit an application. **All parties are placed on notice that any attorney fee application must be filed at this time and must not be withheld pending the outcome of any possible appeals.** The application must conform to 20 C.F.R.§§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a Service Sheet showing that service has been made upon all parties, including

the Claimant and the Solicitor, as Counsel for the Director. Parties so served have ten (10) days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of approval of such application.

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RICHARD E. HUDDLESTON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.